SECOND REGULAR SESSION

HOUSE BILL NO. 2671

102ND GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE GRAGG.

5583H.01I DANA RADEMAN MILLER, Chief Clerk

AN ACT

To repeal sections 208.152 and 208.662, RSMo, and to enact in lieu thereof ten new sections relating to maternal health care services.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 208.152 and 208.662, RSMo, are repealed and ten new sections enacted in lieu thereof, to be known as sections 208.152, 208.662, 208.1400, 208.1405, 208.1410, 208.1415, 208.1420, 208.1425, 376.1213, and 376.1760, to read as follows:

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy persons as described in section 208.151 who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the MO HealthNet division shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the MO HealthNet division shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and

EXPLANATION — Matter enclosed in bold-faced brackets **[**~~thus~~**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the MO HealthNet division not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for participants, except to persons with more than five hundred thousand dollars equity in their home or except for persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. Section **[**~~301,~~**]** **1396** et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The MO HealthNet division when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

(5) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection for those days, which shall not exceed twelve per any period of six consecutive months, during which the participant is on a temporary leave of absence from the hospital or nursing home, provided that no such participant shall be allowed a temporary leave of absence unless it is specifically provided for in his **or her** plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a participant is away from the hospital or nursing home overnight because he **or she** is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere;

(7) Subject to appropriation, up to twenty visits per year for services limited to examinations, diagnoses, adjustments, and manipulations and treatments of malpositioned articulations and structures of the body provided by licensed chiropractic physicians practicing within their scope of practice. Nothing in this subdivision shall be interpreted to otherwise expand MO HealthNet services;

(8) Drugs and medicines when prescribed by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse; except that no payment for drugs and medicines prescribed on and after January 1, 2006, by a licensed physician, dentist, podiatrist, or an

advanced practice registered nurse may be made on behalf of any person who qualifies for prescription drug coverage under the provisions of P.L. 108-173;

(9) Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments;

(10) Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of Section 6403 of **[**~~P.L.~~**]** **Pub. L.** 101-239 **(42 U.S.C. Sections 1396a and 1396d), as amended,** and federal regulations promulgated thereunder;

(11) Home health care services;

(12) Family planning as defined by federal rules and regulations; provided, however, that such family planning services shall not include abortions or any abortifacient drug or device that is used for the purpose of inducing an abortion unless such abortions are certified in writing by a physician to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term;

(13) Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C. Section 1396d, et seq.);

(14) Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

(15) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his or her physician on an outpatient rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the participant's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one participant one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such services, when delivered in a residential care facility or

assisted living facility licensed under chapter 198 shall be authorized on a tier level based on the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal physician. Such authorized units of personal care services or tier level shall be transferred with such resident if he or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as to whether the relevant waivers are approved or a determination of noncompliance is made;

(16) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. Section **[**~~301~~**] 1396 et seq.**, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(b) Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, mental health professional and alcohol and drug abuse professional shall be defined by the department of mental health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, MO HealthNet division, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the MO HealthNet division. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

(17) Such additional services as defined by the MO HealthNet division to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. Section 301, et seq.) subject to appropriation by the general assembly;

(18) The services of an advanced practice registered nurse with a collaborative practice agreement to the extent that such services are provided in accordance with chapters 334 and 335, and regulations promulgated thereunder;

(19) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection to reserve a bed for the participant in the nursing home during the time that the participant is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of MO HealthNet certified licensed beds, according to the most recent quarterly census provided to the department of health and senior services which was taken prior to when the participant is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a participant under this subdivision during any period of six consecutive months such participant shall, during the

same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the participant or the participant's responsible party that the participant intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the participant or the participant's responsible party prior to release of the reserved bed;

(20) Prescribed medically necessary durable medical equipment. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(21) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(22) Prescribed medically necessary dental services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(23) Prescribed medically necessary optometric services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(24) Blood clotting products-related services. For persons diagnosed with a bleeding disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section 338.400, such services include:

(a) Home delivery of blood clotting products and ancillary infusion equipment and supplies, including the emergency deliveries of the product when medically necessary;

(b) Medically necessary ancillary infusion equipment and supplies required to administer the blood clotting products; and

(c) Assessments conducted in the participant's home by a pharmacist, nurse, or local home health care agency trained in bleeding disorders when deemed necessary by the participant's treating physician;

(25) **Doula services as described in sections 208.1400 to 208.1425;**

(26) Childbirth education classes for pregnant women and a support person;

(27) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and for third-party payor average dental reimbursement rates. Such plan shall be subject to appropriation and the division shall include in its annual budget request to the governor the necessary funding needed to complete the four-year plan developed under this subdivision.

2. Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Dental services;

(2) Services of podiatrists as defined in section 330.010;

(3) Optometric services as described in section 336.010;

(4) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs;

(5) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a

nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this subdivision shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions (15) and (16) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by participants under this section shall be in addition to and not in lieu of payments made by the state for goods or services described herein except the participant portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a participant is unable to pay a required

payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the MO HealthNet state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

4. The MO HealthNet division shall have the right to collect medication samples from participants in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for MO HealthNet benefits at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. Section 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for MO HealthNet benefits under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. Section 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the MO HealthNet program shall not increase payments in excess of the increase that

would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. Section 1396a (a)(13)(C).

10. The MO HealthNet division may enroll qualified residential care facilities and assisted living facilities, as defined in chapter 198, as MO HealthNet personal care providers.

11. Any income earned by individuals eligible for certified extended employment at a sheltered workshop under chapter 178 shall not be considered as income for purposes of determining eligibility under this section.

12. If the Missouri Medicaid audit and compliance unit changes any interpretation or application of the requirements for reimbursement for MO HealthNet services from the interpretation or application that has been applied previously by the state in any audit of a MO HealthNet provider, the Missouri Medicaid audit and compliance unit shall notify all affected MO HealthNet providers five business days before such change shall take effect. Failure of the Missouri Medicaid audit and compliance unit to notify a provider of such change shall entitle the provider to continue to receive and retain reimbursement until such notification is provided and shall waive any liability of such provider for recoupment or other loss of any payments previously made prior to the five business days after such notice has been sent. Each provider shall provide the Missouri Medicaid audit and compliance unit a valid email address and shall agree to receive communications electronically. The notification required under this section shall be delivered in writing by the United States Postal Service or electronic mail to each provider.

13. Nothing in this section shall be construed to abrogate or limit the department's statutory requirement to promulgate rules under chapter 536.

14. Beginning July 1, 2016, and subject to appropriations, providers of behavioral, social, and psychophysiological services for the prevention, treatment, or management of physical health problems shall be reimbursed utilizing the behavior assessment and intervention reimbursement codes 96150 to 96154 or their successor codes under the Current Procedural Terminology (CPT) coding system. Providers eligible for such reimbursement shall include psychologists.

15. There shall be no payments made under this section for gender transition surgeries, cross-sex hormones, or puberty-blocking drugs, as such terms are defined in section 191.1720, for the purpose of a gender transition.

16. The department of social services shall study the impact that the childbirth education classes provided under subdivision (26) of subsection 1 of this section have on infant and maternal mortality among pregnant women. The department of social services shall submit a report to the general assembly with the results of the study before January 1, 2027.

208.662. 1. There is hereby established within the department of social services the "Show-Me Healthy Babies Program" as a separate children's health insurance program (CHIP) for any low-income unborn child. The program shall be established under the authority of Title XXI of the federal Social Security Act, the State Children's Health Insurance Program, as amended, and 42 CFR 457.1.

2. For an unborn child to be enrolled in the show-me healthy babies program, his or her mother shall not be eligible for coverage under Title XIX of the federal Social Security Act, the Medicaid program, as it is administered by the state, and shall not have access to affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. In addition, the unborn child shall be in a family with income eligibility of no more than three hundred percent of the federal poverty level, or the equivalent modified adjusted gross income, unless the income eligibility is set lower by the general assembly through appropriations. In calculating family size as it relates to income eligibility, the family shall include, in addition to other family members, the unborn child, or in the case of a mother with a multiple pregnancy, all unborn children.

3. Coverage for an unborn child enrolled in the show-me healthy babies program shall include all prenatal care and pregnancy-related services that benefit the health of the unborn child and that promote healthy labor, delivery, and birth**, including childbirth education classes**. Coverage need not include services that are solely for the benefit of the pregnant mother, that are unrelated to maintaining or promoting a healthy pregnancy, and that provide no benefit to the unborn child. However, the department may include pregnancy-related assistance as defined in 42 U.S.C. Section 1397ll.

4. There shall be no waiting period before an unborn child may be enrolled in the show-me healthy babies program. In accordance with the definition of child in 42 CFR 457.10, coverage shall include the period from conception to birth. The department shall develop a presumptive eligibility procedure for enrolling an unborn child. There shall be verification of the pregnancy.

5. Coverage for the child shall continue for up to one year after birth, unless otherwise prohibited by law or unless otherwise limited by the general assembly through appropriations.

6. (1) Pregnancy-related and postpartum coverage for the mother shall begin on the day the pregnancy ends and extend through the last day of the month that includes the sixtieth day after the pregnancy ends, unless otherwise prohibited by law or unless otherwise limited by the general assembly through appropriations. The department may include pregnancy-related assistance as defined in 42 U.S.C. Section 1397ll.

(2) (a) Subject to approval of any necessary state plan amendments or waivers, beginning on July 6, 2023, mothers eligible to receive coverage under this section shall receive medical assistance benefits during the pregnancy and during the twelve-month period

that begins on the last day of the woman's pregnancy and ends on the last day of the month in which such twelve-month period ends, consistent with the provisions of 42 U.S.C. Section 1397gg(e)(1)(J). The department shall seek any necessary state plan amendments or waivers to implement the provisions of this subdivision when the number of ineligible MO HealthNet participants removed from the program in 2023 pursuant to section 208.239 exceeds the projected number of beneficiaries likely to enroll in benefits in 2023 under this subdivision and subdivision (28) of subsection 1 of section 208.151, as determined by the department, by at least one hundred individuals.

(b) The provisions of this subdivision shall remain in effect for any period of time during which the federal authority under 42 U.S.C. Section 1397gg(e)(1)(J), as amended, or any successor statutes or implementing regulations, is in effect.

7. The department shall provide coverage for an unborn child enrolled in the show-me healthy babies program in the same manner in which the department provides coverage for the children's health insurance program (CHIP) in the county of the primary residence of the mother.

8. The department shall provide information about the show-me healthy babies program to maternity homes as defined in section 135.600, pregnancy resource centers as defined in section 135.630, and other similar agencies and programs in the state that assist unborn children and their mothers. The department shall consider allowing such agencies and programs to assist in the enrollment of unborn children in the program, and in making determinations about presumptive eligibility and verification of the pregnancy.

9. Within sixty days after August 28, 2014, the department shall submit a state plan amendment or seek any necessary waivers from the federal Department of Health and Human Services requesting approval for the show-me healthy babies program.

10. At least annually, the department shall prepare and submit a report to the governor, the speaker of the house of representatives, and the president pro tempore of the senate analyzing and projecting the cost savings and benefits, if any, to the state, counties, local communities, school districts, law enforcement agencies, correctional centers, health care providers, employers, other public and private entities, and persons by enrolling unborn children in the show-me healthy babies program. The analysis and projection of cost savings and benefits, if any, may include but need not be limited to:

(1) The higher federal matching rate for having an unborn child enrolled in the show-me healthy babies program versus the lower federal matching rate for a pregnant woman being enrolled in MO HealthNet or other federal programs;

(2) The efficacy in providing services to unborn children through managed care organizations, group or individual health insurance providers or premium assistance, or through other nontraditional arrangements of providing health care;

(3) The change in the proportion of unborn children who receive care in the first trimester of pregnancy due to a lack of waiting periods, by allowing presumptive eligibility, or by removal of other barriers, and any resulting or projected decrease in health problems and other problems for unborn children and women throughout pregnancy; at labor, delivery, and birth; and during infancy and childhood;

(4) The change in healthy behaviors by pregnant women, such as the cessation of the use of tobacco, alcohol, illicit drugs, or other harmful practices, and any resulting or projected short-term and long-term decrease in birth defects; poor motor skills; vision, speech, and hearing problems; breathing and respiratory problems; feeding and digestive problems; and other physical, mental, educational, and behavioral problems; and

(5) The change in infant and maternal mortality, preterm births and low birth weight babies and any resulting or projected decrease in short-term and long-term medical and other interventions.

11. The show-me healthy babies program shall not be deemed an entitlement program, but instead shall be subject to a federal allotment or other federal appropriations and matching state appropriations.

12. Nothing in this section shall be construed as obligating the state to continue the show-me healthy babies program if the allotment or payments from the federal government end or are not sufficient for the program to operate, or if the general assembly does not appropriate funds for the program.

13. Nothing in this section shall be construed as expanding MO HealthNet or fulfilling a mandate imposed by the federal government on the state.

208.1400. Sections 208.1400 to 208.1425 shall be known and may be cited as the "Missouri Doula Reimbursement Act".

208.1405. For purposes of sections 208.1400 to 208.1425, the following terms mean:

(1) "Accountable care payer", an accountable care organization that helps coordinate the medical care provided to patients eligible for MO HealthNet benefits;

(2) "Antepartum", the period of pregnancy before labor or childbirth. Services provided during this period are rendered to the pregnant individual;

(3) "Community-based organization", a public or private nonprofit organization that is representative of a community or significant segments of a community and engaged in meeting that community's needs in the area of social, human, or health services;

(4) "Competencies", key skills and applied knowledge necessary for doulas to be effective in the work field and carry out their roles;

(5) "Doula" or "perinatal doula", a trained professional providing continuous physical, emotional, and informational support to a pregnant individual, from the antepartum, the intrapartum, and up to the first twelve months of the postpartum periods. Doulas also provide assistance by referring childbearing individuals to community-based organizations and certified and licensed perinatal professionals in multiple disciplines;

(6) "Doula services", services provided by a certified doula as described in section 208.1415;

(7) "Doula training organization", a state, national, or international entity recognized by the department of health and senior services for training perinatal doulas with educational requirements in the core curriculum topics described in sections 208.1400 to 208.1425 including, but not limited to, the International Childbirth Education Association (ICEA), DONA International, ToLabor, Birthworks, the Childbirth and Postpartum Professional Association (CAPPA), Childbirth International, the International Center for Traditional Childbearing, Commonsense Childbirth, Inc., the Missouri Community Doula Council, and The Doula Network;

(8) "Fee-for-service", a payment model where services are unbundled and paid for separately;

(9) "Intrapartum", the period of pregnancy during labor and delivery or childbirth. Services provided during this period are rendered to the pregnant individual;

(10) "Managed care", the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations that accept a set per member per month (capitation) payment for these services;

(11) "Postpartum", the one-year period after a pregnancy ends;

(12) "Registry", a list of doulas, maintained by the department of health and senior services, who satisfy the qualifications for registration set forth by the department of health and senior services.

208.1410. 1. Doula services shall be eligible for coverage throughout Missouri for childbearing individuals through MO HealthNet and through health benefit plans as described in section 376.1760.

2. Doula services shall be covered by the MO HealthNet program if the doula seeking reimbursement has completed the following:

(1) Applied for and received a national provider identification number;

(2) Completed and received approval for all required MO HealthNet program provider enrollment forms;

(3) Provided a copy of a doula training certificate or an authentic, original, signed, and dated letter from a doula training organization verifying that the doula has attended and completed the training or curriculum of the doula training organization. To be considered authentic, a letter shall be required to be on the doula training organization's letterhead and signed by an authorized representative; and

(4) Provided a signed and dated attestation of being trained in the following competencies through one program or a combination of programs, the result of which is meeting all doula core competency requirements outlined as follows:

(a) An education that includes any combination of childbirth education, birth doula training, antepartum doula training, and postpartum doula training;

(b) Attendance at a minimum of one breast-feeding class or holding a valid lactation certification;

(c) Attendance at a minimum of one childbirth class or valid childbirth education certification;

(d) Completion of training in client confidentiality or the requirements of the federal Health Insurance Portability and Accountability Act of 1996, as amended;

(e) Completion of cardiopulmonary resuscitation certification for children and adults; and

(f) Completion of ServSafe certification for meal preparation.

3. Once enrolled as a MO HealthNet program provider, a doula shall be eligible to enroll as a provider with fee-for-service, managed care, and accountable care payers affiliated with the MO HealthNet program.

4. In order to follow federal Medicaid and private insurance requirements applicable to covered services, doula services shall be reimbursed on a fee-for-service schedule.

5. Notwithstanding the provisions of subsection 2 of this section, a doula who can provide alternative and sufficient documentation of training and practice as a doula for a period of at least six months before the effective date of this section shall not be required to provide the certificate or letter required by subdivision (3) of subsection 2 of this section and shall have six months after the effective date of this section to complete the training requirements of subdivision (4) of subsection 2 of this section.

208.1415. 1. A doula may provide services to a pregnant individual such as:

(1) Providing services to support pregnant mothers and people, improve birth outcomes, and support new mothers and families with culturally specific antepartum, intrapartum, and postpartum services, referrals, and advocacy;

(2) Advocating for and supporting physiological birth, breast-feeding, and parenting for clients;

(3) Supporting such individual during the antepartum, intrapartum, and postpartum periods with traditional comfort measures and educational materials, as well as assistance during the transition to parenthood in the initial postpartum period through home visits;

(4) Empowering individuals and families with evidence-based information to choose best practices for birth, breast-feeding, and infant care;

(5) Providing continuous support to the laboring individual until the birth of the baby at any location of delivery;

(6) Referring clients to their appropriate provider for medical advice for care outside of the scope of practice of the doula;

(7) Working as a member of the individual's multidisciplinary team; and

(8) Offering evidence-based information on newborn and infant feeding, emotional and physical recovery from childbirth, and other issues related to the antepartum, intrapartum, and postpartum periods.

2. A doula shall not engage in the practice of medicine as described in chapter 334.

208.1420. 1. The department of health and senior services shall promulgate rules and regulations that establish a doula's area of professional competence and services for the purpose of implementing the requirements of section 376.1760 and that establish a statewide certification for perinatal doulas solely for the purpose of establishing the qualifications necessary for doulas to qualify for reimbursement under sections 208.1400 to 208.1425. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2024, shall be invalid and void.

2. Individuals seeking entry on the statewide registry of doulas shall, at a minimum:

(1) Be at least eighteen years of age;

(2) Successfully complete training in all competencies as outlined in section 208.1410;

(3) Receive and maintain certification by the department of health and senior services; and

(4) Maintain personal liability insurance either individually or through a collaborative, association, or business of doulas that can prove liability insurance coverage for all doulas working through, with, or under them.

3. The department of health and senior services shall establish a process for individuals to renew certification under this section in order to have their names continue to appear on the statewide registry of doulas. The department of health and senior services may contract with doula training organizations, including, but not limited to, the Missouri Community Doula Council, to assist in the certification renewal process.

208.1425. 1. The MO HealthNet coverage available for doula services per pregnancy, regardless of the number of infants involved, which shall be billed on a fee-for-service basis, shall be available through one year postpartum, shall not be less than one thousand five hundred dollars, and shall be eligible toward the following activities:

(1) Prenatal visits;

(2) Physical and emotional support during a childbearing individual's labor and childbirth;

(3) Telephone or virtual communications between the doula and the client;

(4) Time spent being on call for the birth;

(5) Postpartum visits; and

(6) Time spent on administrative tasks, such as documentation or paperwork.

2. The MO HealthNet program, managed care organizations, and accountable care payers that are required to cover perinatal doula services under section 208.1410 shall report utilization and cost information related to perinatal doula services to the department of social services before July 1, 2026, and each July first thereafter. The department of social services shall define the utilization and cost information required to be reported.

376.1213. Each entity offering individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law, and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2025, and providing for maternity benefits, shall provide coverage for childbirth education classes.

376.1760. 1. For purposes of this section, the following terms mean:

(1) "Health benefit plan", the same meaning given to the term in section 376.1350;

(2) "Health carrier", the same meaning given to the term in section 376.1350;

(3) "Perinatal doula", the same meaning given to the term in section 208.1405.

2. Each health carrier and health benefit plan that offers or issues health benefit plans that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2025, shall provide coverage for the services of perinatal doulas if the services are within the perinatal doulas' area of professional competence as defined by regulations promulgated by the department of health and senior services.

3. Supervision, signature, or referral by any other health care provider shall not be required as a condition of reimbursement under this section except when such supervision, signature, or referral is also applicable to other categories of health care providers.

4. A health carrier or health benefit plan shall not be required to pay for duplicate services actually rendered by both a perinatal doula and any other health care provider.

5. Direct payment for perinatal doulas shall be contingent upon services rendered in accordance with rules and regulations promulgated by the department of health and senior services.

6. Every health carrier and health benefit plan required to cover perinatal doula services under this section shall report utilization and cost information related to perinatal doula services to the department of commerce and insurance before July 1, 2026, and each July first thereafter. The department of commerce and insurance shall define the utilization and cost information required to be reported.

7. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy of six months' or less duration, or any other supplemental policy as determined by the director of the department of commerce and insurance.

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